Section 5
Attachments

Attachment A

Competitive POS Application Checklist

Proposal Application Checklist

Applicant: _____ RFP No.: HTH 420-2-06

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the state purchasing agency as part of the Proposal Application. *SPO-H forms are located on the web at http://www.spo.hawaii.gov Click *Procurement of Health and Human Services* and *For Private Providers.**

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
General:				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	**X**	
Proposal Application Checklist	Section 1, RFP	Attachment A	**X**	
Table of Contents	Section 5, RFP	Section 5, RFP	**X**	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	**X**	
Registration Form (SPO-H-100A)	Section 1, RFP	SPO Website*	**(Required if not Registered)**	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*	**X**	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions is applicable, Section 5	**X**	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions, Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*	**X**	
SPO-H-206B	Section 3, RFP	SPO Website*	**X**	
SPO-H-206C	Section 3, RFP	SPO Website*	**X**	
SPO-H-206D	Section 3, RFP	SPO Website*	**X**	
SPO-H-206E	Section 3, RFP	SPO Website*	**X**	
SPO-H-206F	Section 3, RFP	SPO Website*	**X**	
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*	**X**	
SPO-H-206I	Section 3, RFP	SPO Website*	**X**	
SPO-H-206J	Section 3, RFP	SPO Website*	**X**	
Certifications:				
Federal Certifications		Section 5, RFP	**X**	
Debarment & Suspension		Section 5, RFP	**X**	
Drug Free Workplace		Section 5, RFP	**X**	
Lobbying		Section 5, RFP	**X**	
Program Fraud Civil Remedies Act		Section 5, RFP	**X**	
Environmental Tobacco Smoke		Section 5, RFP	**X**	
Program Specific Requirements:				
Certification of Compliance with HRS 103-55		Section 5, RFP	**X**	

_____ _____

Authorized Signature Date

Attachment B

Sample Table of Contents for the POS Proposal Application

Proposal Application
Table of Contents

Attachment C

Draft Special Conditions

SPECIAL CONDITIONS

1. Time of Performance. The PROVIDER shall provide the services required under this Agreement from _____, to and including _____, unless this Agreement is extended or sooner terminated as hereinafter provided.

2. Option to Extend Agreement. Unless terminated, this Agreement may be extended by the STATE for specified periods of time not to exceed three (3) years or for not more than three (3) additional twelve (12) month periods, without resolicitation, upon mutual agreement and the execution of a supplemental agreement. This Agreement may be extended provided that the Agreement price shall remain the same or is adjusted per the Agreement Price Adjustment provision stated herein. The STATE may terminate the extended agreement at any time in accordance with General Conditions no. 4.

3. Agreement Price Adjustment. The Agreement price may be adjusted prior to the beginning of each extension period and shall be subject to the availability of state funds.

4. Audit Requirement. The PROVIDER shall conduct a financial and compliance audit in accordance with the guidelines identified in Exhibit _____ attached hereto and made a part hereof. Failure to comply with the provisions of this paragraph may result in the withholding of payments to the PROVIDER.

5. The PROVIDER shall have bylaws or policies that describe the manner in which business is conducted and policies that relate to nepotism and management of potential conflicts of interest.

Attachment D

Consumer Rights

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.909**
AMHD Administration	Effective Date: 10/29/04 History: New
SUBJECT: Consumer Rights	Page: 1 of 7
REFERENCE:	APPROVED: _____ Title: Chief, AMHD

PURPOSE

To ensure that specified rights of each consumer are protected.

POLICY

A. Each provider shall have a statement designed to protect consumer's rights. The statement shall be:

   1. Consistent with Federal and State laws and regulations; and

   2. Posted in strategic and conspicuous areas to maximize consumer, family and staff awareness.

B. Each consumer shall have a consumer rights statement that complies with AMHD consumer rights requirements. The statement shall be:

   1. Signed and dated by the consumer prior to treatment; and

   2. Maintained in the treatment records of consumers.

PROCEDURE

A. The statement given to consumers must include at the minimum the following language:

   1. You have rights no matter what your situation is. Adult Mental Health Division (AMHD) and all its providers will uphold these rights. You have these rights regardless of your:

- Age
- Race
- Sex
- Religion
- Culture
- Amount of education
- Lifestyle
- Sexual orientation
- National origin
- Ability to communicate
- Language spoken
- Source of payment for services
- Physical or mental disability

2. You have the right to be treated with respect and dignity, and to have your right to privacy respected.

3. You have the right to know about the AMHD and the services available to you. You have the right to know who will provide the services you use, their training, and experience.

4. You have the right to know as much information about your treatment and service choices as you need so you can give an informed consent or refuse treatment. This information must be told to you in a way you can understand. Except in cases of emergency services, this information shall include a description of the treatment, medical risks involved, any alternate course of treatment or no treatment and the risks involved in each.

5. You have a right to information about your medications; up to and including your right not to take them, what they are, how to take them, and known side effects.

6. You have a right to be informed of continuing care following discharge from the hospital or outpatient services.

7. You have a right to look at and get an explanation of any bills for non-covered services, regardless of who pays.

8. You have a right to receive emergency services when you, as a prudent layperson, acting reasonably, would believe that an emergency medical condition existed. Payment for emergency services will not be denied in cases when you go for emergency services.

9. You have a right to receive emergency services when traveling outside the State of Hawaii when something unusual prevents you from getting care from an AMHD provider.

10. You have a right to usually have the same provider when you get services.

11. You have a right to an honest discussion with your providers of the options for your treatment, regardless of cost and benefit coverage.

12. You have a right to be advised if a provider wants to include you in experimental care or treatment. You have the right to refuse to be included in such research projects.

13. You have a right to complete an advance directive, living will, psychiatric advance directive, medical durable powers of attorney or other directive to your providers.

14. You have a right to have any person who has legal responsibility make decisions for you regarding your mental health care. Any person with legal responsibility to make health care decisions for you will have the same rights as you would.

15. You have the right to know all your rights and responsibilities.

16. You have the right to get help from AMHD in understanding your services.

17. You are free to use your rights. Your services will not be changed and you will not be treated differently if you use your rights.

18. You have the right to receive information and services in a timely way.

19. You have the right to be a part of all choices about your treatment. You have the right to have a copy of your written Individual Service Plan.

20. You have the right to disagree with your treatment or to ask for changes in your Individual Service Plan.

21. You have the right to ask for a different provider or case manager. If you want a different provider or case manager, we will work with you to find another one in the AMHD network. There is no guarantee that you will be provided a new case manager right away, however.

22. You have the right to refuse treatment or medication, or both, to the extent allowed by the law. You are responsible for your actions if you refuse treatment or if you do not follow your providers' advice.

23. You have the right to receive services that are responsive to your racial and ethnic culture including language, histories, traditions, beliefs, and values.

24. You have the right to an interpreter, if needed, to help you speak to AMHD or your providers. You have the right to have an interpreter in the room when your provider sees you.

25. You have the right to ask us to send you mail and call you at the address or telephone number of your choice, in order to protect your privacy. If we cannot honor your request, we will let you know why.

26. You have a right to a second opinion when deciding on treatment.

27. You have the right to expect that your information will be kept private according to the Privacy law.

28. You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.

29. You have the right to be free from being restrained or secluded unless a doctor or psychologist approves, and then only to protect you or others from harm. Seclusion and restraints can never be used to punish you or keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

If you have any questions or concerns about these rights, you can speak to the Rights Advisor at your Community Mental Health Center or call the AMHD Consumer Advisor at (808) 586-4688.

B. Each consumer must be provided an orientation to the program at a level educationally appropriate for the consumer, communicated in either the consumer's native language or sign language, as is appropriate for the individual. Documentation of the orientation must be kept in the consumer's treatment record and signed and dated by the consumer. If a consumer who received the orientation refuses to sign the form acknowledging that he/she received information regarding his/her rights, the staff shall document on the form that the consumer refuses to sign and the date that the information was provided to the consumer. At a minimum such orientation must include:

1. An explanation of the:

    a) Rights and responsibilities of the consumer,

    b) Grievance and appeal procedures

    c) Ways in which input is given regarding:

        - the quality of care
        - achievement of outcomes
        - satisfaction of the consumer

2. An explanation of the organization's:

    a) Services and activities

    b) Expectations

    c) Hours of operation

d) Access to after-hour services

e) Code of ethics

f) Confidentiality policy

g) Requirements for follow-up for the mandated consumer served, regardless of his or her discharge outcome

3. An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization

4. Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits

5. The program's policies regarding:

   a) Use of seclusion or restraint

   b) Smoking

   c) Illicit or licit drugs brought into the program

   d) Weapons brought into the program

6. Identification of the person responsible for case management

7. A copy of the program rules to the consumer, that identifies the following:

   a) Any restrictions the program may place on the consumer

   b) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the consumer

   c) Means by which the consumer may regain rights or privileges that have been restricted

8. Education regarding advance directives, when legally applicable

9. Identification of the purpose and process of the assessment

10. A description of how the Individualized Service Plan (ISP) or other plan will be developed and the consumer's participation

11. Information regarding transition criteria and procedures

12. When applicable, an explanation of the organization's services and activities will include:

    a) Expectations for consistent court appearances

    b) Identification of therapeutic interventions, including:

    - Sanctions
    - Interventions
    - Incentives
    - Administrative discharge criteria

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment E

Division P&P Regarding Consumer Grievances

Division P&P Regarding Consumer Appeals

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.906**
AMHD Administration	Effective Date: 10/26/04 History: New
SUBJECT: Consumer Grievances	Page: 1 of 6
REFERENCE: Consumer Appeals, Consumer Rights, Recovery Guide	APPROVED: _____ Title: Chief, AMHD

PURPOSE

To outline the internal process and procedure for reviewing and resolving consumer grievances or any expressions of dissatisfaction.

POLICY

The grievance process is administered by Adult Mental Health Division's (AMHD) Office of Consumer Affairs.

A description of AMHD's grievance process is included in the Recovery Guide, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing a grievance.

DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or grievances not acted upon within prescribed timeframes.

- Appeal – A request for review of an action made by AMHD, as "action" is defined. Consumer Appeals are discussed in a separate policy and procedure.

- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.

- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as "action" is defined.

- Grievance Review – A review process for grievance resolutions. A consumer may request a "grievance review" by AMHD if they do not agree with a provider's resolution of a grievance.

- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD's or a provider's operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

PROCEDURE

1. Inquiry

    A. Consumers should call their Case Manager for any inquiry or question regarding any aspect of AMHD or a provider's operations, activities, or behavior, or request to change to another provider.

    B. If during the contact, the consumer expresses dissatisfaction of any kind, the inquiry becomes an expression of dissatisfaction and becomes a Grievance or Appeal (see Grievance and Appeal process below).

2. Grievance

    A. Consumers may file a grievance to express any dissatisfaction in regards to the following:

        - AMHD or provider's operations

        - AMHD or provider's activities

        - AMHD or provider's failure to respect the consumer's rights

- AMHD or provider's behavior
- Provider or AMHD employee is rude
- Provider quality of care
- AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.

B. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer, may file a grievance orally or in writing.

(1) For oral filing of grievance, the consumer may call the Office of Consumer Affairs and a Consumer Specialist will assist the consumer in writing the grievance by completing an AMHD Consumer Grievance Form (see Attachment A), however, any AMHD staff may assist the consumer to complete the Grievance Form. The Consumer will be given an option to receive a copy of the written grievance. The form is forwarded to the individual responsible for tracking grievances within the Office of Consumer Affairs who is defined as the Grievance Coordinator.

(2) If a provider or an authorized representative on behalf of the consumer files the grievance orally, the consumer must give their written authorization.

(3) The Grievance Coordinator directs the grievance to the appropriate individual within AMHD for investigation and resolution of the grievance. That individual forwards the written results of their investigation and resolution to the Grievance Coordinator for data entry and tracking.

(4) All written grievances should be submitted to:

Adult Mental Health Division
Office of Consumer Affairs
Grievance Coordinator
P.O. Box 3378
Honolulu, Hawaii 96801-3378

(5) Within five (5) working days of the receipt date, the grievant will be informed by letter that the grievance has been received.

(6) Each grievance will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

(7) AMHD will render a resolution of the grievance within thirty (30) calendar days of the receipt date. If the thirtieth (30^{th}) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered the next working day. A letter of resolution will be mailed to the grievant and copies are sent to all parties whose interest has been affected by the decision. If the grievant has requested not to be identified, consumer identifying information will be left off other parties' letters.

(8) The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

C. The resolution letter includes and describes the following details:

- Nature of the grievance
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures.
- A statement that AMHD's resolution of the grievance is final, unless the consumer requests an appeal by contacting the Office of Consumer Affairs.

D. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests an extension or if additional information is needed. In this case, a letter will be sent to the grievant. The content of the notification will include the following details:

- Nature of the grievance
- Reason for the extension of the decision and how the extension is in the consumer's interest

3. Appeals

   A. Consumers may file an appeal for the following actions or decisions made by AMHD:

      - Prior authorization for a service is denied or limited
      - The reduction, suspension, or termination of a previously authorized service
      - The denial, in a whole or in part, of payment for a service
      - The denial of eligibility
      - Failure to provide services in a timely manner
      - Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
      - Not satisfied with resolution of grievance

   B. The appeal process is discussed in a separate policy and procedure.

4. Other Requirements

   A. The AMHD Grievance Coordinator shall compile an aggregate quarterly grievance report and submit such report to the Quality Improvement Committee in the required format no later than forty-five (45) days from the end of each quarter.

      The Aggregate Grievance Report shall at a minimum include the following elements:

      (1) Number of grievances sorted by date, nature of the grievance, county, and provider of services, if applicable;

      2) Status of Resolution and if resolved, result including feedback, and

      3) Turn-around times.

B. An Aggregate Annual Grievances Report shall be prepared and presented to the Quality Improvement Committee within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis by county, and recommendations for improvement of clinical and service areas.

C. Privacy of the grievance records is maintained at all times, including the transmittal of medical records.

D. All grievances and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of grievance.

E. All grievances that concern provider organization actions and are proven quality of care or non-compliance with AMHD contracts or policies and procedures will be forwarded and collated by AMHD Performance Management and used in certification and contract review activities.

ATTACHMENTS

Consumer Grievance Form

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment A

Consumer Grievance Form

Date Received: _____

Taken by: _____

Consumer Name: _____

AMHD ID#: _____

Mailing Address: _____

Island: _____

Telephone #: _____

Name of Grievant: _____

Relationship to Consumer: _____

Mailing Address: _____

Telephone Number: _____

Note: If a representative is filing an oral grievance on behalf of an adult consumer, please obtain a written authorization from the consumer through the Authorization To Disclose Protected Information form.

Type of Contact: ☐ Letter
☐ Telephone
☐ In Person

Consumer Request Copy of Grievance? Yes ☐ No ☐

Grievance Regarding:

☐ Provider

Full Name: _____

☐ AMHD

[Attachment to AMHD Policy #60.906]
[October 26, 2004]

Date(s) Problem began: _____

Description of Grievance: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ Reviewed written grievance with consumer verbally on: _____

For Grievance Coordinator Use Only:

File#: _____

Sent copy of grievance to consumer on ___/___/___
Sent acknowledgement letter on ___/___/___
Sent to _____on ____/_____/_____

New 12/03/03 hj

[Attachment to AMHD Policy #60.906]
[October 26, 2004]

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.903**
AMHD Administration	Effective Date: 05/01/03 History: Rev. 10/04, 05/05
SUBJECT: Consumer Appeals	Page: 1 of 9
REFERENCE: Plan for Community Mental Health Services IV, B, 1, a, i, Consumer Grievances, Denial Letter, Recovery Guide HRS 91	APPROVED: _____ Title: Chief, AMHD

PURPOSE

To outline the process by which a consumer may appeal an action or decision made by Adult Mental Health Division (AMHD).

POLICY

The consumer appeals process is administered by the Office of Consumer Affairs.

A description of AMHD's appeals process is included in the Consumer Handbook, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing an appeal.

Medicaid eligible consumers also have the right to request a Fair Hearing for appeals related to Medicaid reimbursable services provided by AMHD. This process does not require a Medicaid eligible consumer to appeal to AMHD first.

DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or appeals not acted upon within prescribed timeframes.

- Appeal – A request for review of an action made by AMHD, as "action" is defined.

- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.

- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as "action" is defined.

- Grievance Review - A review process for grievance resolutions. A consumer may request a "grievance review" by AMHD if they do not agree with a provider's resolution of a grievance.

- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD's or a provider's operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

- Medicaid – A federal program administered by the Department of Human Services, Med-QUEST Division which provides medical coverage. Medicaid recipients can receive services from the Fee-for-service program or QUEST managed care health plans.

PROCEDURE

1. Inquiry

    A. Consumers should call their Case Manager for any inquiry or question regarding any aspect of AMHD or a provider's operations, activities, or behavior, or request to change to another provider.

    B. If during the contact, the consumer expresses dissatisfaction of any kind, the Inquiry becomes an expression of dissatisfaction and becomes a Grievance (see Grievance and Appeal process below).

2. Grievance

    A. Consumers may file a grievance if they express any dissatisfaction in regards to the following:

        - AMHD or provider's operations

        - AMHD or provider's activities

- AMHD or provider failure to respect the consumer's rights
- AMHD or provider's behavior
- Provider or AMHD employee is rude
- Provider quality of care
- AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.

B. The grievance process is administered by the Office of Consumer Affairs as delineated in the Consumer Grievances Policy and Procedures.

3. Appeals

A. Consumers may file an appeal for the following actions or decisions made by AMHD:

- Prior authorization for a service is denied or limited
- The reduction, suspension, or termination of a previously authorized service
- The denial, in a whole or in part, of payment for a service
- The denial of eligibility
- Failure to provide services in a timely manner
- Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
- Not satisfied with resolution of grievance

B. AMHD Utilization Management shall notify consumers about their appeal rights and processes at the time of denial of eligibility or service request. Consumers shall have access to consumer advocacy and AMHD shall assure that any consumer who requests an advocate for this process shall be linked to this assistance.

C. Consumers who wish to appeal a decision regarding a Medicaid reimbursable service provided by AMHD and who are Medicaid recipients have the right to ask for a Fair Hearing from the Department of Human Services. These appeals do not have to go through the AMHD appeals process first. Medicaid recipients are directed to contact their Department of Human Services worker for information and assistance.

D. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer with the consumer's written consent or if documentation is available to demonstrate the consumer is incapacitated, may file an appeal orally or in writing.

E. For oral filing of appeal, the consumer (or consumer's representative with the written consent of the consumer or if documentation is available to demonstrate the consumer is incapacitated), may call the Office of Consumer Affairs and must also submit a follow-up written appeal.

F. The designated case manager, or the designated crisis support manager, may appeal on behalf of the consumer without written consent if documentation is available to demonstrate the consumer is incapacitated. The case manager or crisis support manager shall provide specified clinical information to support the appeal request.

G. An AMHD Consumer Appeal Form (see Attachment A) may also be completed on behalf of the consumer or consumer's representative. In this case, the completed Consumer Appeal Form will be sent to the consumer or the consumer's authorized representative if a written authorization has been received for review and signature.

H. The consumer or the consumer's authorized representative must submit the follow-up written appeal or return the signed Consumer Appeal Form to the AMHD Office of Consumer Affairs which is designated as the AMHD Consumer Appeals Coordinator within one (1) week from the receipt date of the oral appeal. If the follow-up written appeal or the signed Consumer Appeal form is not received within the allotted timeframe, a follow-up call will be made to the consumer or the consumer's representative. If the consumer requests an extension for the filing deadline of the written appeal, AMHD will grant another one (1) week to submit the written appeal.

I. If a written follow-up is not received, the appeal will be closed after thirty (30) calendar days without further action or investigation. The consumer will receive written notification of this.

J. If a provider files a written appeal on behalf of a consumer, it will be initially designated as a Provider Complaint unless accompanied by the consumer's written consent. If the written appeal is filed with the consumer's written consent, AMHD will contact the provider to determine if consent was given. If the written consent is received, AMHD will transfer the Provider Complaint to a Consumer Appeal.

K. All written appeals should be submitted to:

Adult Mental Health Division
Office of Consumer Affairs
Consumer Appeal
P.O. Box 3378
Honolulu, Hawaii 96801-3378

4. First Level Appeal

A. The appeal must be filed within thirty (30) days from the date of the initial action or decision made by AMHD. Exceptions to this deadline may be granted if details regarding extenuating circumstances are provided. At no time will an appeal be considered that is 180 days from the date of the initial action or decision made by AMHD.

B. Within five (5) working days of receipt of the written appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.

C. The consumer or authorized representative of the consumer may request to examine the consumer's case file, including medical records and any other documents considered during or before the appeal process by contacting the AMHD Consumer Appeals Coordinator in accordance with federal and state privacy regulations.

D. All appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

E. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal.

F. The AMHD Medical Director shall review the denial and shall make a determination (overturning or ratifying the denial). The AMHD Medical Director has the option of obtaining a second physician opinion prior to rendering an appeal decision.

G. AMHD will render a resolution of the appeal within thirty (30) calendar days of the receipt date except in the case of an expedited appeal. If the thirtieth (30^{th}) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the provider and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

H. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Process for a second level appeal if appeal denied

I. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests the extension or if additional information is needed. In this case, a letter will be sent to the consumer. The content of the notification will include the following details:

- Nature of the appeal
- Reason for the extension of the decision and how the extension is in the best interest of the consumer

5. Expedited Appeals

A. Any AMHD consumer (or provider acting on behalf of the consumer with the consumer's written authorization) may request an expedited appeal.

B. An expedited appeal may be authorized if the standard review time frame of AMHD's appeal process may:

- Seriously jeopardize the life or health of the consumer

- Seriously jeopardize the consumer's ability to access services with limited availability with a resulting loss of function

C. All expedited appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory and contractual provisions, as well as AMHD's policies and procedures.

D. The AMHD Medical Director will review all expedited appeals.

E. A decision will be rendered within forty-eight (48) working hours of receipt of the request for an expedited appeal.

F. The decision will be phoned by the AMHD Consumer Appeals Coordinator to the consumer and provider.

G. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Process for a second level appeal if appeal denied

6. Second Level Appeal

A. The consumer or appealing party may proceed with a written second level appeal within thirty (30) calendar days from the date of the first level appeal determination letter.

B. The second level appeal letter along with any additional clinical information shall be sent to the AMHD Chief who shall obtain all relevant documentation from the AMHD UM Coordinator and the AMHD Medical Director. The second level appeal will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

C. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal by the AMHD Chief.

D. Expedited appeals which result in an expedited second level appeal shall be reviewed and a decision rendered within forty-eight (48) working hours of receipt of the request for an expedited second level appeal if the request has been designated as such. The decision shall be phoned by the AMHD Consumer Appeals Coordinator to the consumer and provider.

E. Within five (5) working days of receipt of the written non-expedited second level appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.

F. AMHD will render a resolution of the appeal for non-expedited appeal within thirty (30) calendar days of the receipt date except in the case of expedited appeal. If the thirtieth (30^{th}) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the consumer and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

G. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Statement concerning any other avenues of appeal, if any, available to the appellant.

H. Consumers or their legal representatives who wish to appeal further must follow the Department of Health administrative appeals process, HR91f, or pursue through the legal system.

7. Other Requirements

   A. The AMHD Consumer Appeals Coordinator shall compile a quarterly aggregate appeal report and submit such report to the AMHD Quality Council in the required format no later than forty-five (45) days from the end of each quarter.

      The aggregate Appeals Report shall include at a minimum include the following elements:

      (1) Number of appeals sorted by date, nature of the appeal, county level of appeal, and provider of services, if applicable,

      (2) Number of decisions upheld,

      (3) Number of decisions overturned, and

      (4) Turn-around times.

   B. An aggregate Annual Appeals Report shall be prepared and presented to the AMHD Quality Council within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis, and recommendations for improvement of clinical and service areas.

   C. Privacy of the appeal records is maintained at all times, including the transmittal of medical records.

   D. All appeals and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of appeal.

   E. All appeals that concern provider organization actions and are proven quality of care matters or non-compliance with the terms and conditions of AMHD contracts or policies and procedures will be forwarded and collated by AMHD Performance Management and used in certification and contract review activities.

ATTACHMENT

Consumer Appeal Form

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment A

Consumer Appeal Form

Print Name of Consumer: _____

AMHD ID#: _____

Mailing Address: _____

Island: _____

Phone Number: _____

Signature of Consumer: _____ Date Signed: _____

Note to Consumer: By signing this form, you as a consumer are authorizing your provider or any representative (if there's any) to file this appeal on your behalf.

** Please fill out this section if a provider or a representative is filing the appeal on behalf of the consumer**

Print Name of Representative: _____

Relationship to Consumer: _____

Phone Number: _____

Mailing Address: _____

Signature of Representative: _____ Date Signed: _____

Description of Service: _____

Date(s) of Service: _____

Describe on the space below what you disagree with and why. Also include copies of any papers that have to do with the appeal.

(Write on back of this form if you need more space. Or write your appeal on a separate sheet and attach to this form)

<u>You must sign this form and send it back to us within one (1) week.</u>

Please send it to:
Adult Mental Health Division, Attn. Consumer Appeals Coordinator, P.O. Box 3378, Honolulu, Hawaii 96801-3378. Or if you need help, call us at (808)586-4688 (Oahu)

Attachment F

QMHP AND SUPERVISION

Qualified Mental Health Professional (QMHP)

A Qualified Mental Health Professional ("QMHP") is defined as a Licensed Psychiatrist, Licensed Clinical Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Licensed Advanced Practice Registered Nurse (APRN) in behavioral health currently licensed in the State of Hawaii.

The QMHP shall oversee the development of each consumer's treatment plan to ensure it meets the requirements stated in the Community Plan 2003 and sign each treatment plan.

The QMHP shall serve as a consultant to the treatment team.

The QMHP shall serve as the LOCUS expert.

The QMHP shall provide oversight and training.

The QMHP shall review and sign each authorization request for clinical services prior to submittal to ensure that the services requested are medically necessary.

The QMHP shall provide clinical consultation and training to team leaders and/or direct care providers as needed.

Additionally, for Specialized Residential Treatment Programs, the QMHP shall provide day-to-day program planning, implementation, and monitoring.

Mental Health Professionals (MHP)

Except for Assertive Community Treatment ("ACT"), the team leader is not required to be a QMHP. Non-QMHP team leaders shall be clinically supervised by a QMHP.

Non-QMHP team leaders are defined as Mental Health Professionals ("MHP") and shall meet the following minimum requirements:

- Licensed Social Worker (LSW); or
- Master of Science in Nursing (MSN); or
- APRN in a non-behavioral health field; or
- Master's degree from accredited school in behavioral health field
    a) Counseling, or
    b) Human Development, or
    c) Marriage, or
    d) Psychology, or
    e) Psychosocial Rehabilitation, or
    f) Criminal Justice.
- Master's degree in health related field with two (2) years experience in behavioral health; or

- Licensed Registered Nurse with a Bachelors in Nursing and five (5) years experience in behavioral health

The MHP may supervise para-professional staff if the MHP is clinically supervised by a QMHP.

The MHP may function as the DIVISION Utilization Management Liaison.

Supervision:

Clinical supervision of all staff is ongoing and shall be sufficient to ensure quality services and improve staff clinical skills and is according to community standards, scope of license as applicable, and agency policies and procedures. Treatment team meetings are consumer focused whereas clinical supervision is staff focused. Therefore, treatment team meetings do not need to meet clinical supervision requirements.

One-on-one clinical supervision of MHP team leaders and direct care providers, if there is no MHP team leader, shall be performed by the QMHP at a minimum of once per month. If a MHP is the team leader, the MHP shall provide one-on-one monthly clinical supervision of non-MHP and non-QMHP staff.

The supervision shall be documented in writing, legible, signed and dated by the QMHP or MHP as directed by the provider agency's policies and procedures.

The DIVISION funded PROVIDER shall have policies and procedures to select and monitor the MHP team leaders if non-QMHP team leaders are used.

The QMHP and non-QMHP staff do not have to work in the same physical setting but shall have routine meetings as defined in the PROVIDER's policies and procedures.

Attachment G

AMHD Level of Care Service Criteria

AMHD SERVICE STANDARDS: Targeted Case Management
SERVICE COMPONENTS

TARGETED CASE MANAGEMENT (TCM)

Service Definition	Targeted case management services assists individuals to gain access to necessary services to reduce psychiatric and addiction symptoms and to develop optimal community living skills. Services include, but are not limited to, maintenance of a supportive relationship to assist with problem solving and development of necessary skills to sustain recovery, regular contact for the purpose of assessing or reassessing needs for planning or monitoring services, contact with collaterals (family and agency) to mobilize services and provide support and education. Advocacy on behalf of the individual, coordination of services specified in the plan, such as medication management and rehabilitation services, and some limited crisis intervention. The goals of targeted case management are reflective of the goals of Intensive Case Management: 1) realization of recovery and vocation/personal goals, 2) Lessen/eliminate debilitating symptoms of mental illness and to minimize or prevent recurrent acute episodes of the illness through rehabilitation and progressive treatment interventions, 3) Ensure that consumers have the basic needs and skills for sustaining community living and enhancing the quality of life, 4) Improve/establish new linkages with a variety of community services and mobilize the involvement of the consumer's support network, 5) Maintain consumer engagement in treatment, 6) Promote harm reduction, substance use reduction, abstinence, and recovery for SPMI consumers with co-occurring substance abuse/addiction by providing substance abuse services. Targeted case management services are authorized to include all clinic based treatment services. Units of authorization include targeted case management, psychiatric evaluations, medication review with psychotherapy, intramuscular therapy, individual therapy, group therapy, somatic treatment, family therapy (with consumer), family therapy (without consumer), pharmacological management, and clinical visits by nurses.
Level of Care	LOCUS Level 2
Population Focus	Adults who are registered and eligible for Adult Mental Health Division services who meet the following criteria.
Initial Authorization	Up to 365 days, 100 units (1 unit= 15 minutes)
Re-Authorization	Up to 365 days, 100 units (1 unit= 15 minutes)

Admission Criteria	Meets all of the following: 1. Consumer is capable of living in the community either in supportive or independent settings, and does not require intensive supervision or very frequent contact in order to access needed services 2. Low risk of harm to self and others 3. Moderate or less functional impairment as evidenced by at least one of the following: a. Troubled significant relationships but impulsive or abusive behaviors are under control b. Appearance and hygiene are below usual standards on a frequent basis c. Serious disturbances in vegetative activities but not serious threat to health d. Neglect or avoidance on some occasions of ability to fulfill social or vocational responsibilities and obligations e. Deficits in interpersonal relationships but able to engage in socially constructive activities f. Recent stabilization has been achieved through structured and/or protected setting 4. Either there is no co-morbidity or, if a medical or substance abuse problem exists, the problem may not adversely affect, or be adversely affected, by the presenting disorder to the extent that it may require medical monitoring 5. Consumer's environment may be moderately stressful with limited or few supports but more intensive intervention is not necessary in order for consumer to access needed services and supports 6. Treatment and recovery history supports this level of case management as evidenced by one of the following: a. Most symptoms are controlled but intensive or repeated interventions were required b. Recovery has been managed for moderate periods of time with limited support or structure 7. Consumer has shown positive engagement in treatment and has some recognition/responsibility for illness and recovery.
Continued Stay Criteria	Meets all of the following: 1. Continues to meet initial criteria 2. In order to maintain current community stability, requires this level of service at least 1 time per month, face-to-face contact with case manager 3. There is documented evidence that consumer is showing stabilization/improvements in the areas of functional status, increased environmental supports, and engagement to reasonably conclude that continued services at this level will further stabilize/increase consumer's functioning

Discharge Criteria	Meets one of the following: 1. Service no longer needed due to all of the following a. Functional stability has been maintained in the current community setting in the past 12 months b. In order to maintain current community stability, requires less than 1 time per month face-to-face contact with a similar service 2. Consumer is in inpatient facility with expectation of stay to exceed 90 days 3. Consumer is in specialized treatment service that incorporates case management services 4. Consumer refuses case management services at this level
Service Exclusions	No other case management service would be appropriate while consumer is receiving this service.
Clinical Exclusion	Consumers who require inpatient services or who are in specialized treatment services as a result of discharge from inpatient. Consumers who can maintain functioning with less intensive case management interventions or who show increased risk factors for harm or hospitalization would not be appropriate.

1. Documentation in the treatment record shall include actual begin and end time of service.

AMHD SERVICE STANDARDS: Care Coordination
SERVICE COMPONENTS

CARE COORDINATION	
Service Definition	Care coordination is the least intensive level of case management services and is a recovery maintenance and health management service. The consumer is receiving at least one other service arranged for or provided by the Division. Case management services are not routinely needed or provided due to consumer's ability to access needed services or due to stabile and natural supports that serve as case managers for the consumer in the community. Care coordination services are authorized to include all clinic based treatment services. Units for authorization include all clinic based treatment services. Units of authorization include case management, psychiatric evaluations, medication review with psychotherapy, intramuscular therapy, individual therapy, group therapy, somatic treatment, family therapy (with consumer), family therapy (without consumer), pharmacological management, and clinical visit by nurses. Care coordination is normally provided by any professional member of the clinic staff. This service assures that the consumer continue to have an individual Master Treatment Plan, is accessing needed services, and is maintaining current level of functioning in the community while receiving clinic or other services(s) arranged for or provided by the Division. Face-to-face consumer contract by the designated care coordinator occurs at least once every three months.
Level of Care	LOCUS Level 1
Population Focus	Adults who are registered and eligible for Adult Mental Health Division services who meet the following criteria.
Initial Authorization	Unit-15 minutes: 48 units: 365 days
Re-Authorization	Unit-15 minutes: 48 units: 365 days
Admission Criteria	Meets all of the following criteria: 1. Consumer is capable of living in the community either in supportive or independent settings, and does not require frequent contact in order to access needed services 2. Low risk of harm to self and others 3. Mild or less functional impairment as evidenced by at least one of the following: a. Meaningful/satisfying relationship are maintained although there

	may be some mild conflict and hostility in relationships b. Minor disruptions in self care or usual activities c. Minor difficulties in social role functioning and meeting social/vocational responsibilities d. Significant improvements have followed a period of deterioration 4. Either there is no co-morbidity or, if a medical or substance abuse problem exists, the problem does not adversely affect, or be adversely affected, by the presenting disorder 5. There are sufficient supports in the environment to address routine needs 6. There has been significant response to treatment and recovery management for moderate periods of time
Continued Stay Criteria	Meets all of the following: 1. Continues to meet initial criteria 2. In order to maintain current community stability, requires this level of service at least 1 time every 3 months by designated care coordinator 3. There is documented evidence that consumer is showing stabilization/improvements in the areas of functional status, environmental supports, and engagement to reasonably conclude that continued services at this level will continue stabilization or will increase consumer's functioning
Service Exclusions	Meets one of the following: 1. Service no longer needed due to all of the following a. Functional stability has been maintained in the current community setting in the past 24 months b. In order to maintain current community stability, requires less than 1 time every 3 months face-to-face contact with a similar service 2. Consumer is in inpatient facility with expectation of stay to exceed 90 days 3. Consumer is in specialized treatment service that incorporates case management services 4. Consumer refuses case management services at this level
Clinical Exclusions	No other case management service would be appropriate while consumer is receiving this service.

Attachment H

Comprehensive, Continuous, Integrated System of Care Model by Kenneth Minkoff, M.D.

Comprehensive, Continuous, Integrated System of Care Model

By Kenneth Minkoff, M.D.

The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

1. *Dual diagnosis is an expectation, not an exception:* Epidemiologic data defining the high prevalence of comorbidity, along with clinical outcome data associating individuals with co-occurring psychiatric and substance disorders ("ICOPSD") with poor outcomes and high costs in multiple systems, imply that the whole system, at every level, must be designed to use all of its resources in accordance with this expectation. This implies the need for an integrated system planning process, in which each funding stream, each program, all clinical practices, and all clinician competencies are designed proactively to address the individuals with co-occurring disorders who present in each component of the system already.

2. *All ICOPSD are not the same; the national consensus four quadrant model for categorizing co-occurring disorders (NASMHPD, 1998) can be used as a guide for service planning on the system level.* In this model, ICOPSD can be divided according to high and low severity for each disorder, into high-high (Quadrant IV), low MH – high SA (Quadrant III), high MH – low SA (Quadrant II), and low-low (Quadrant I). High MH individuals usually have SPMI and require continuing integrated care in the MH system. High SA individuals are appropriate for receiving episodes of addiction treatment in the SA system, with varying degrees of integration of mental health capability.

3. *Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting; provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties.* The system needs to prioritize a) the development of clear guidelines for how clinicians in any service setting can provide integrated treatment in the context of an appropriate scope of practice, and b) access to continuous integrated treatment of appropriate

intensity and capability for individuals with the most complex difficulties.

4. *Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting.* Each individual client may require a different balance (based on level of functioning, available supports, external contingencies, etc.); and in a comprehensive service system, different programs are designed to provide this balance in different ways. Individuals who require high degrees of support or supervision can utilize contingency based learning strategies involving a variety of community based reinforcers to make incremental progress within the context of continuing treatment.

5. *When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.* The system needs to develop a variety of administrative, financial, and clinical structures to reinforce this clinical principle, and to develop specific practice guidelines emphasizing how to integrate diagnosis-specific best practice treatments for multiple disorders for clinically appropriate clients within each service setting

6. *Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989) with parallel phases of recovery (acute stabilization, motivational enhancement, active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.* Literature in both the addiction field and the mental health field has emphasized the concept of stages of change or stages of treatment, and demonstrated the value of stagewise treatment (Drake et al, 2001.)

7. *There is no single correct intervention for ICOPSD; for each individual interventions must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery/stage of change, and (in a managed care system) multidimensional assessment of level of care requirements.* This principle forms the basis for developing clinical practice guidelines for assessment and treatment matching. It also forms the basis for designing the template of the CCISC, in which

each program is a dual diagnosis program, but all programs are not the same. Each program in the system is assigned a "job": to work with a particular cohort of ICOPSD, providing continuity or episode interventions, at a particular level of care. Consequently, all programs become mobilized to develop cohort specific dual diagnosis services, thereby mobilizing treatment resources throughout the entire system.

8. *Clinical outcomes for ICOPSD must also be individualized, based on similar parameters for individualizing treatment interventions.* Abstinence and full mental illness recovery are usually long term goals, but short term clinical outcomes must be individualized, and may include reduction in symptoms or use of substances, increases in level of functioning, increases in disease management skills, movement through stages of change, reduction in "harm" (internal or external), reduction in service utilization, or movement to a lower level of care. Systems need to develop clinical practice parameters for treatment planning and outcome tracking that legitimize this variety of outcome measures to reinforce incremental treatment progress and promote the experience of treatment success.

Attachment I

Dual Diagnosis Philosophy and Treatment Guidelines

DUAL DIAGNOSIS
PHILOSOPHY AND TREATMENT GUIDELINES

GUIDING PRINCIPLES:

- We agree that psychiatric and substance disorders tend to be persistent and recurrent, and that co-occurrence of these disorders occurs with sufficient frequency in both systems that a continuous and integrated approach to assessment and treatment is required.
- We agree that individuals with co-occurring serious and persistent mental illness and substance disorders should be regarded as having two (or more) co-occurring primary disorders, each of which requires specific assessment and diagnosis, and appropriately intensive treatment. The presence of co-occurring disorders makes each disorder more difficult to treat.
- We agree that the recommended treatment approach for individuals with co-occurring serious and persistent mental illness and substance disorders is an integrated dual primary treatment in which:
    - Each individual has a primary treatment relationship with a clinician, or team of clinicians.
    - Each individual receives specific, and appropriately intensive, primary treatment for each disorder that takes into account the complications resulting from the co-occurring disorder.
    - Each individual receives integrated and coordinated treatment for both disorders in a single setting.
- We agree that because the underlying goal of working together is to improve consumer outcomes, any successful program must be consumer-centered. A consumer-centered system is one in which dual diagnosis consumers and their families are actively involved, not only in treatment decisions, but also in program design, administration and evaluation. The role of consumers in advancing care for people with serious and persistent mental illness should be the cornerstone in program planning.

TREATMENT PHILOSOPHY:

- Serious, persistent psychiatric disorders and substance disorders are both examples of primary psychiatric or behavioral illness that can utilize a disease and recovery model for conceptualizing assessment, treatment, and rehabilitation.
- The program must incorporate the recovery model. Recovery is defined as an ongoing personal process of empowerment by which an individual overcomes the negative impact of a psychiatric disability (and other co-occurring disabilities), regains hope, self-esteem, self-worth, pride, dignity and meaning by acquiring increasing ability to maintain stabilization or remission of the disorder, and maximizing functioning with appropriate supports despite the possible ongoing constraints of the disorder.
- Every individual, regardless of the severity and disability associated with each disorder, is entitled to experience the promise and hope of dual recovery, and considered to have the potential to achieve dual recovery.

- Bringing optimism to the treatment process creates consumer motivation. Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationship, which takes place over time and often in multiple treatment episodes.

PSYCHOPHARMACOLOGY GUIDELINES:

- Initial psychopharmacologic evaluation in mental health should not require consumers to be abstinent.
- Initial psychopharmacologic evaluation in substance disorder treatment should occur as early in treatment as possible, and incorporate capacity to maintain existing non-addictive psychotropic medication during detoxification and early recovery.
- Psychopharmacology with individuals with co-occurring disorders is not an absolute science. It is best performed in the context of an ongoing, empathic clinical relationship. Treatment should emphasize a continuous re-evaluation of diagnosis and medication, and artful utilization of medication strategies to promote outcome of both disorders.

The applicant must have expertise in Best Practices and Evidenced Based Practices in the area of treatment for individuals with serious and persistent mental illness and a co-occurring substance use disorder defined in the literature by a variety of authors, including but not limited to, Robert E. Drake, Ken Minkoff, JO Prochaska. The applicant shall also provide a listing of verifiable experience with projects or contracts for the most recent five years that are pertinent to the proposed services.

Attachment J

Treatment Services Definitions

Diagnostic/Functional Assessment. Intensive clinical and functional evaluation which results in a treatment plan that documents and identifies needed services and supports, goals and objectives related to the provision of these services and supports, and methods for achieving the objectives. Required components include: (1) evidence that an interdisciplinary team process was conducted; (2) evidence of consumer participation including families and/or guardians where required; (3) assessment of a person's psychological, neuropsychological, psychiatric, psychosocial, and physical health (including nutrition) associated with a person's mental health, as well as conducting a risk and developmental assessment; and (4) periodic review of the treatment plan which shall occur no less frequently than every ninety (90) days. This service also includes the assessment of the need for psychiatric hospitalization for persons being referred to psychiatric inpatient services to assure less restrictive alternatives are considered and evaluated when appropriate.

Biopsychosocial Rehabilitative Programs. A set of therapeutic and rehabilitative social skill building services which promotes resiliency and recovery and which allows children with serious emotional or behavioral disturbance and adults with serious mental illness to gain the necessary social, independent living, work-related, and communication skills necessary to allow them to remain in or return to communities of their choice and access naturally occurring community supports. Services include, but are not limited to: individual or group skill building activities that focus on the development of problem-solving techniques, independent living skills, social skills, medication management, and recreational activities that improve self-esteem.

Crisis Management. This service provides mobile assessment for children or adults in an active state of crisis twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the consumer's home, local emergency departments, etc. It does not include transportation time to and from clinic/hospital and community settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, and medical stability, explore service options in the community, and assure immediate crisis resolution and de-escalation as applicable. The presenting crisis situation is one where it is medically necessary to deliver the services in the consumer's home or natural environment setting as the consumer does not have the resources to present at the clinic for crisis services.

Licensed Crisis Residential Services. This service offers short-term, acute interventions to individuals experiencing crisis. This is a structured residential alternative or diversion from psychiatric inpatient hospitalization. Licensed Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, daily living skills training, and linkage to other services, as needed.

Counseling and Psychotherapy Services. Individual, group or family face-to-face services include symptom/behavior management, development, restoration, or enhancement of adaptive behaviors and skills, enhancement or maintenance of daily living skills. These skills include those necessary to access community resources and support systems, interpersonal skills, and restoration or enhancement of the family unit and/or support of the family.

Medication/Somatic Treatment. Medical interventions include: physical examinations; prescription, supervision or administration of psychoactive medications; monitoring of diagnostic studies; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Activities include promoting compliance, evaluating the clinical effectiveness of the medication, monitoring and treating the side effects of medication and any adverse reactions, and providing education and direction for symptom and medication self-management. Group treatment is always therapeutic, educational, and interactive with a strong emphasis on group member selection, peer interaction, and support as specified in the treatment plan.

Assertive Community Treatment (ACT). ACT is an intensive case management community service for adults discharged from the state or community hospitals after multiple or extended stays. Intensive, integrated rehabilitative, crisis, treatment, and community support services provided by an interdisciplinary staff team is available twenty-four (24) hours per day, seven (7) days per week. Services offered by the ACT team must be documented in a treatment plan and must include (in addition to those provided by other systems): some medication prescription, administration, and monitoring medication and self medication; crisis assessment and intervention; symptom assessment, management, and individual supportive therapy; substance abuse and co-occurring disorders treatment; psychosocial rehabilitation and skill development; personal, social, and interpersonal skill training; consultation, education, and support for individuals, families, and their support systems; representative payee and money management; and general client support services.

Intensive Case Management. This is an intensive community rehabilitation service for adults at-risk of hospitalization, or for crisis residential or high acuity substance abuse services. Treatment and restorative interventions assist individuals to gain access to necessary services to reduce psychiatric and addiction symptoms and to develop optimal community living skills. Services can be provided by a team or an individual case manager and documented in a treatment plan. Services provided by the intensive case management team or individual include: assistance and support for the individuals in crisis situations; service coordination; consultation, education, and support for individuals, families, and their support systems; individual restorative interventions for the development of interpersonal, community coping, and independent living skills; development of symptom monitoring and management skills; medication prescription, administration, and monitoring medication and self medication; representative payee and money management; and treatment for substance abuse or other co-occurring disorders.

Screening. Determination of an individual's need and eligibility for psychiatric services, as well as registration for psychiatric evaluation and treatment.

Targeted Case Management. The least intensive model of case management and it is generally used in conjunction with at least one additional community mental health service. Interventions employed to assist eligible individuals in gaining access to needed medical services, including psychiatric, social, educational, vocational, and other services. Services include, but are not limited to, maintenance of a supportive relationship to assist with problem solving and development of necessary skills to sustain recovery; regular contact for the purpose of assessing or reassessing needs for planning or monitoring services; contact with collaterals (family and agency) to mobilize services and provide support and education; advocacy on behalf of the individual; coordination of services specified in the plan, such as medication management and rehabilitation activities; and some limited crisis intervention.

Treatment Planning. Development of a comprehensive, individualized document specifying treatment modalities and interventions to be provided for the consumer that is approved by a licensed psychiatrist, licensed psychologist, or licensed advanced psychiatric practice nurse. The plan is derived from the assessment and includes:

1. DSM – IV, five axes diagnoses;
2. Signs and symptoms expressed in measurable terms;
3. Specification of needs or problems which are barriers to consumer's enhancement of independent psychosocial functioning;
4. Integration of consumer's preferences, expectations, strengths, and expressed goals;
5. Clearly stated measurable, output performance, and outcome measurements;
6. Intervention and treatment methods which specifically address identified needs or problems;
7. Identification of staff, community supports, other professionals responsible for treatment or interventions;
8. Medications prescribed;
9. A prognosis expressed in expected length of stay in current level of care.

Licensed psychiatrists shall approve treatment plans for consumers who have prescribed medications. Licensed psychologists and licensed advanced practice psychiatric nurses may approve treatment plans for consumers who have not been prescribed medications. There should be some cooperation between all three on all treatment plans in case some consumers have unidentified needs.

Supported Housing Program. This program provides housing for persons who are able to live in the community with appropriate supports. This type of housing is directed to those individuals who desire, and are capable of, living independently with flexible tailored services in accordance with their needs. Services are provided, with prior authorization from the Adult Mental Health Division ("DIVISION"), to targeted consumers and include, but are not limited to, assisting consumers in search of housing,

developing and sustaining working relationships with local landlords and property managers, working collaboratively with DIVISION-designated case managers regarding consumer/tenant status, and assisting consumers/tenants in meeting tenancy requirements under the Supported Housing Program.

Pharmaceuticals. As defined in Chapter 10 of the Medicaid Provider's Manual, "pharmacy services as allowed by the Medicaid program pays for medically necessary and non-experimental drugs and pharmacy services with certain limitations." The dispensement and drug formulary shall be in accordance with the guidelines as specified in Chapter 19 of the Medicaid Provider Manual Pharmacy Services (Date issued: November 15, 2001; Date revised: November 5, 2001).

Medical Supplies. As defined in Chapter 10 of the Medicaid Provider Manual, "durable medical equipment, prosthetic and orthotic devices and medical supplies (DMEPOS) include medically necessary equipment/appliances/items provided either through purchase or rental and prescribed by a physician for the maximum reduction of medical disability and for the restoration or maximum improvement in the patient's functional level."

Ancillary Services. Not considered as a main part of a patient's treatment milieu. Services are regarded as supportive services which may include durable medical equipment and medical supplies, as defined in Chapter 10 of the Medicaid Provider Manual.

Attachment K

Certifications

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

CERTIFICATION OF COMPLIANCE WITH HAWAII REVISED STATUTES 103-55

Hawaii Revised Statutes §103-55 Wages, hours, and working conditions of employees of contractors performing services. Requires that:

(a) Before any offeror enters into a contract to perform services in excess of $25,000 for any governmental agency, the offeror shall certify that the services to be performed will be performed under the following conditions:

Wages. The services to be rendered shall be performed by employees paid at wages or salaries not less than the wages paid to public officers and employees for similar work.

Compliance with labor laws. All applicable laws of the federal and state governments relating to workers' compensation, unemployment compensation, payment of wages, and safety will be fully complied with.

The undersigned authorized official signing for the organization applying for a contract with the State of Hawaii certifies that:

_____The organization understands and will fully comply with the requirements of HRS 103-55.

The organization is exempt from the requirements of the statute because:

_____ The proposed contract funds managerial, supervisory, or clerical personnel exempt from the requirements of the statute.

_____ The proposed contract is for supplies, materials, or printing.

_____ The proposed contract is for utility services.

_____ The proposed contract is to perform personal services under paragraphs (2), (3), (12), and (15) of section 76-16, paragraphs (7), (8), and (9) of section 46-33, and paragraphs (7), (8), and (12) of section 76-77.

_____ The proposed contract is for professional services.

_____ The proposed contract is for the operation of refreshment concessions in public parks, or to provide food services to educational institutions.

_____ The applicant organization is a nonprofit institution.

Signature of Authorized Certifying Official	Title
Applicant Organization	Date Submitted

Attachment L

Form SPO-H-205A
Instructions

Instructions for Completing
FORM SPO-H-205A ORGANIZATION - WIDE BUDGET BY SOURCE OF FUNDS

Applicant/Provider:	Enter the Applicant's legal name.
RFP#:	Enter the Request For Proposal (RFP) identifying number of this service activity.
For all columns (a) thru (d)	Report your total organization-wide budget for this fiscal year by **source of funds**. Your organization's budget should reflect the total budget of the "organization" legally named. Report each source of fund in separate columns, by budget line item. For the first column on the first page of this form, use the column heading, "Organization Total". For the remaining columns you may use column headings such as: Federal, State, Funds Raised, Program Income, etc. If additional columns are needed, use additional copies of this form.
Columns (b), (c) & (d)	Identify sources of funding in space provided for column titles.
TOTAL (A+B+C+D)	Sum the subtotals for Budget Categories A, B, C and D, for columns (a) through (d).
SOURCE OF FUNDING: **(a)** **(b)** **(c)** **(d)**	Identify all sources of funding to be used by your organization.
TOTAL REVENUE	Enter the sum of all revenue sources cited above.
Budget Prepared by:	Type or print the name of the person who prepared the budget request and their telephone number. If there are any questions or comments, this person will be contacted for further information and clarification. Provide signature of Applicant's authorized representative, and date of approval.

Special Instructions by the State Purchasing Agency:

Provide a budget by source of funds for this specific service activity.